Generic and individual approaches to intervention in crisis situations are presented and discussed in this paper with special reference to the use of mental health personnel and other personnel. The discussion relates particularly to the similarities and differences in theory and practice.

GENERIC AND INDIVIDUAL APPROACHES TO CRISIS INTERVENTION

Gerald F. Jacobson, M.D.; Martin Strickler, A.C.S.W.; and Wilbur E. Morley, Ph.D.

IN several recent papers,[1-6] my colleagues and I have reported on the program of the Benjamin Rush Center for Problems of Living, a division of the Los Angeles Psychiatric Service. The Los Angeles Psychiatric Service is a community-supported outpatient clinic, engaged in direct service to adults, training in psychiatry and the other mental health professions, research and community service.

The Benjamin Rush Center division of the Los Angeles Psychiatric Service was established in 1962. To date, upward of 2,000 individual patients have been seen in three and one-half years of operation. The characteristics of the Benjamin Rush Center are:

1. Service is available to any individual over 17½ years of age, or to any family, regardless of financial or diagnostic considerations. Fees are charged according to ability to pay.
2. Immediate treatment is offered—on the day the patient walks in, if possible—subject only to availability of staff.
3. Treatment deals with the immediate problem, or crisis, rather than with long-established modes of functioning.
4. Treatment is carried out by a team of psychiatrists, psychologists, and psychiatric social workers, under psychiatric direction. A psychiatric nurse serves as program coordinator.

The present paper is concerned with some theoretical issues inherent in crisis intervention.

The Nature of Crisis

As Caplan[7] defines it, "A crisis is provoked when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many different abortive attempts at solution are made. Eventually some kind of adaptation is achieved which may or may not be in the best interests of that person or his fellows."

It should be noted that a complete characterization of any crisis must include references to social, intrapsychic, and somatic factors, in other words to the biopsychosocial field. A crisis may result from change in any one area, and such a change may result in crisis processes involved in all areas.

Relevant to the social factor in crisis are role changes or other alterations in the interpersonal balance. Intrapsychic aspects are most readily conceptualized as referring to changes in a previously

existing equilibrium within the psychic apparatus, and involving unconscious as well as conscious processes. Somatic changes may also be significant in the instigation and/or subsequent course of crisis as exemplified by the work of Lindemann[8] on the relation of pathologic grief to chronic psychosomatic illness.

There is a further distinction between the hazard or hazardous situation and the crisis proper. The hazard is that social, intrapsychic or somatic change which in certain circumstances may result in a crisis. Examples of hazard are loss of significant relationships through death or separation, birth of premature or deformed children, or physical illness. A crisis results only if the individual experiencing the hazard does not have a previously developed coping mechanism available to deal with the hazard. Such coping technics are acquired throughout life, so that each individual must inevitably pass through a succession of crises, as he encounters new hazards. Each successfully mastered crisis in turn adds to his coping armamentarium. For this reason, crisis has been described as both a danger and an opportunity.

It follows that certain hazards uniformly result in crises whereas others may or may not do so. Examples of the former are the life crises described by Erikson, which occur as each person for the first time encounters a new stage in life as he progresses from birth through childhood, adult life, and into old age. Loss by death, or other means, of important other persons also invariably results in a new situation for which previous coping mechanisms could not be available, and requires a new crisis process before it can be resolved. On the other hand, the loss of employment or physical illness may or may not result in a crisis for any one person, depending on whether he is equipped to handle the situation within himself and in the external world by previously established methods.

The outcome of each crisis is of great significance for the individual. Any crisis may result in solutions which are in varying degrees adaptive or maladaptive. Adaptive solutions are reality-oriented, result in the acceptance of what is inevitable, in strengthening of interpersonal ties, in renewed intrapsychic equilibrium without neurotic or psychotic manifestation and, as mentioned, in the enrichment of the coping repertory. Maladaptive responses, on the other hand, are inappropriate to the reality situation, and may result in lasting interpersonal disturbances or in newly formed or exacerbated neurotic or psychotic syndromes. The implications for prevention are obvious.

There are a number of factors which influence the outcome of any given crisis, consisting not only of the objective nature of the hazard, i.e., the extent of the real threat to effective functioning, but of a number of other factors as well. These include experience with other crises encountered earlier, revival of memories and fantasies of loss or failure with associated fear and guilt, constitutional factors, cultural and socioeconomic prescriptions, and the amount and kind of support available in the environment during crisis. It is the last-named factor that leads us to considerations of crisis intervention.

Crisis Intervention

Crisis intervention may be defined as activities designed to influence the course of crisis so that a more adaptive outcome will result, including the ability to better cope with future crisis. If classified according to the means employed, crisis intervention may be divided into two major categories which may be designated as individual or generic. These two approaches are complementary. Both concepts have their

roots in the growing literature on crisis and crisis intervention[9] but have not previously been explicitly formulated or differentiated from each other.

Generic Approach

Its central thesis is that for each crisis, such as bereavement, birth of premature children, divorce, and so on, there are certain identifiable patterns, some of which result in adaptive and others in maladaptive outcome. This approach is particularly well documented in the work of Lindemann[8] on bereavement. Lindemann found that a bereaved person goes through a well-defined process in adapting to the death of a relative, consisting of the so-called "grief work" which includes preoccupation with the image of the deceased person, usually in connection with the revival of memories of joint activities. While most persons grieve appropriately, some do not. Failure to complete the grief process is believed to be a potential cause of later psychiatric or psychosomatic illness. Work aimed at examining distinct adaptive or maladaptive patterns with regard to another crisis, that of premature birth, has been described by Caplan, Mason, and Kaplan.[10]

There is no attempt to determine or assess the specific psychodynamics of the individual involved in the crisis. Rather, the focus is on the course that a particular *kind* of crisis characteristically follows and a corresponding treatment plan aimed toward adaptive resolution of the crisis.

Intervention consists of specific measures designed to be effective for the target group as a whole. Approaches include direct encouragement of adaptive behavior, general support, environmental manipulation, and anticipatory guidance. This broad approach to all members of a given group with relative disregard of individual differences permits a partial conceptual analogy to such public health measures as immunization and water fluoridation.

It is one of the merits of this conceptualization that it provides a rationale for a type of crisis intervention which may be carried out by persons not specifically trained in the mental health field, such as nonpsychiatric physicians, nurses, welfare workers, and so on. In brief, the generic approach emphasizes (1) specific situational and maturational events occurring to significant population groups, (2) intervention oriented to crises related to these specific events, and (3) intervention carried out by nonmental health professionals. An example of the generic approach follows.

Case Report

A public health nurse visited the home of a couple in their early 30's, both high-school teachers, who had one week earlier brought home their newborn and first baby. The baby boy was grossly deformed and diagnosed immediately by the obstetrician and pediatrician as almost certainly severely mentally impaired.

The nurse found the mother alone with the baby and in a highly lethargic and depressed state. The mother managed to communicate that she was "just waiting" for the State Hospital to contact her and take "it" into permanent placement. She was vague about any details of arranging the placement and indicated that she and her husband found it very hard to talk to each other. Before the baby's birth she felt that there was very good communication between them. Her mother called her frequently to caution her about getting involved with the baby and to remind her that the physician had told her in the hospital to handle the baby as little as possible, i.e., to just care for its physical needs so as not to get emotionally attached to the baby.

The nurse noted that the mother constantly referred to the baby as "it" and

kept a physical distance from the baby's crib. She said to the mother, "Look, this is your baby. It came out of you and you have a right to hold it and cuddle it." Thereupon, the nurse picked up the baby and put it in the mother's trembling hands. The nurse stayed for another half-hour while the mother looked at and stroked the baby.

On the next visit, several days later, there was a dramatic change in the mother's appearance, for she was quite alert, active, and talkative. In response to the nurse's comments on this change, the mother said that a lot had happened since she had last seen her. She had been crying on and off for the first time since the baby's birth, had displayed anger at her husband's passivity in planning for the baby's hospitalization, and now they were talking to each other again. The husband had set up appointments with the State Hospital staff for conferences on the consideration of placement.

The nurse asked what caused such changes in such a short period. The mother stated that it started when the nurse put the baby into her arms and encouraged her to look at it and recognize that it was her baby. The nurse had been the only person who had not cautioned her about thinking of the baby as a "real living thing." Although she now feels the terrible pain of her disappointment and the loss over the prospect of giving up her baby, she herself feels more alive again.

The nurse encouraged her in this and in subsequent visits to talk about her feelings, her disappointment, shame, and guilt, as well as her sorrow about the impending loss of the baby.

This illustrates a case of preventive help where the individual diagnoses of the mother and father were not known or explored, but where the necessary grief work was permitted to emerge and take a healthier course. The training and experience of the public health nurse in crisis situations involving separations or loss were instrumental in her approach to this family.

There are some factors limiting the applicability of the generic approach. First, there are many types of crises for which patterns characteristic of adaptive and maladaptive solutions have not as yet been identified. Further, it appears very likely that among all persons experiencing a common crisis, some proportion will fail to respond to an approach based on the universal characteristics of the crisis, and will require assistance which takes their individual psychological processes into account. For this reason there exists a need for another approach to crisis resolution.

Individual Approach

This is the approach that we have found most helpful in conceptualizing much of our own work in crisis intervention, though we do make use of generic concepts also. The individual approach differs from the generic approach in its emphasis on the assessment by the professional person of the specific intrapsychic and interpersonal processes of the individual(s) in crisis, although this information may not be directly presented to the person. Professional efforts are directed toward the achievement of that solution which is optimal given the *unique* circumstances of the particular situation.

This approach differs from more extended psychotherapy in its lack of concern with long-established processes, except as they provide clues that aid in understanding the current crisis. The focus clearly is on why and how a previous equilibrium had been disturbed, and on the processes involved in the reaching of a new equilibrium. Another differentiation from much conventional therapy is the frequent inclusion in the individual process of family members or other important persons.

Unlike generic technics, individual intervention requires a greater measure of understanding of psychological and psychosocial processes. It is most effectively carried out by individuals with preexisting skills in one of the mental health disciplines, who have undergone further training in the theory and practice of crisis intervention. In brief, the individual approach emphasizes (1) biopsychosocial events unique in the life of a given individual, (2) intervention directed to the individual, and (3) intervention carried out by mental health professionals. A clinical example of the individual approach follows.

Case Report

A 42-year-old woman came to the Benjamin Rush Center acutely anxious and depressed, following the first experience of sexual intercourse that had occurred in her lifetime. She was preoccupied with fears that her lover would abandon her, assured herself that he would contact her, but questioned the value of going on should he fail to do so. It was significant that the sexual experience had followed an automobile accident in which the patient's car had hit that of the friend from the rear. The friend had comforted the patient following this accident, and sexual relations ensued.

The patient's father had committed suicide when the patient was 12 years of age, an event for which the patient was totally unprepared. For a year the patient had totally denied the father's death to herself, yet had been in a very disturbed state, which had not been usual for her previously.

In her subsequent life, she functioned in superior fashion in her chosen occupational area, but her relations with men were casual and she avoided any significant emotional involvement. She had some concern that she might have "homosexual tendencies" because of this apparent lack of interest in men, but had had no homosexual experience. Within a year prior to the acute crisis she had returned to her native country and found that the marker designating her father's grave had been removed in accordance with local customs.

In the course of six visits, it was possible for both therapist and patient to become aware of the manner in which the current crisis was related to the earlier trauma of the father's suicide when the patient was age 12. Since that age, the patient had repressed much of her reaction to the loss of the father, and had developed a characterologic defense consisting of withdrawal from and partial identification with men.

When at last she began to reach out to men—motivated probably by both age-related factors and the reminder of the finality of the loss of the father, due to the removal of the gravestone—she chose a man with whom she became involved in the context of violence (the accident) and who, as it turned out, had no real interest in her, a fact which at first she staunchly denied, as she originally denied her father's death.

This patient was seen for six visits. Treatment was carried out by a resident psychiatrist under the supervision of one of the authors (Dr. Jacobson). The focus was on the current crisis, i.e., the problems relating to the sexual experience and subsequent "abandonment" by the boy friend. The patient was able to achieve insight into the realistically inappropriate nature of her response to this situation, which was either to deny the reality of the loss or to face overwhelming and chaotic feelings of anxiety and depression. The origins of this inappropriate reaction were identified as a chain of specific events beginning with the suicide of the father.

In the opinion of both therapist and supervisor the patient gained meaningful insight into the connections between her current plight and these earlier events.

In this particular case, it was our im-

pression that the patient came to us at a fork in the road in her over-all development, and that it is possible that her gain from crisis intervention may have gone beyond the mastery of the current situation with the boy friend, and may have included the beginnings of a working through of her long-established attitudes toward all men. Only time can tell whether such a result did in fact occur. What is known is that at the end of six visits and at follow-up, three months later, the patient was markedly improved. She showed no signs of acute crisis, but only an appropriate grief reaction over the years she had lost in withdrawing from men. She was making plans to build sounder relationships with men when she was last contacted. The boy friend had never called.

If the generic approach is in some way analogous to such public health measures as immunizations which can be broadly applied to large population groups, the individual approach is analogous to the diagnosis and treatment of a specific disorder in an individual patient. Both appear to have a significant place in comprehensive mental health programs, and both are economical in terms of use of manpower, and important in terms of prevention of long-term disability. Individual approaches, however, require far more skilled personnel, and should therefore be used selectively. Optimum use of individual intervention, in our opinion, would occur if generic crisis intervention were widely available, and care-takers practicing the generic approach could be trained to detect cases which do not appear to respond to the generic approach, and refer these cases to mental health specialists for individual treatment. Another valuable contribution that the individual approach could make consists of gaining additional experience in the natural history of crisis, which would then be used in training of nonmental health professionals using the generic approach.

Summary

Generic and individual approaches to crisis intervention have been outlined and discussed in terms of similarities and differences of theory and practice, with special reference to the use of mental health and nonmental health personnel in crisis intervention.

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Dr. Jacobson is executive director; Mr. Strickler is associate director and director of Social Work Services; and Dr. Morley is associate director and director of Psychological Services; Los Angeles Psychiatric Service and its Benjamin Rush Divisions (8770 Whitworth Drive), Los Angeles, Calif. 90035.

This paper was presented before a Joint Session of the American Orthopsychiatric Association and the Mental Health Section of the American Public Health Association at the Ninety-Fourth Annual Meeting in San Francisco, Calif., November 2, 1966.